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PHILOSOPHICAL CONSIDERATIONS

Bioethics North and South: Creating a common ground

Bioéthique nord et sud : créer un terrain commun

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Summary Bioethics as practiced in Europe, the United States, and Canada has a tenuous and tentative reach into the developing countries of Africa, South America, and Asia. This paper explores the problematic translation of bioethics between the Global North and South; and between resource rich and resource poor countries. As Alexander Capron put it in 2007, bioethics has a 10/90 problem, analogizing to the observation that medical research spends 90% of its resources on problems affecting 10% of the world's population. Today, UNESCO's bioethics website says bioethics focuses on ''stem cell research, genetic testing, cloning, progress in the life sciences''. Any review of the most widely cited bioethics articles and journals finds that the writing is largely centered within an enclave of first world concerns. Stem cells and cloning are neither health care nor health science priorities of developing countries. The priorities of developing countries (i.e., those that would improve the health of populations or that refer to local diseases) are marginalized. Costly and/or impractical medical infrastructure is discussed or proposed. The first-world orientation of bioethics was perhaps somewhat practicable during a post-World War II stasis, but it is increasingly dysfunctional and even dangerous in the context of twenty-first century climate change, refugee movements, and disease vector migrations. A new global bioethics is urgently needed.
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Résumé La bioéthique telle que pratiquée en Europe, aux États-Unis et au Canada a une portée ténue et provisoire dans les pays en développement. Cet article s'intéresse à la transposition problématique de la bioéthique du Nord global vers le Sud ; et des pays riches en ressources vers ceux pauvres en ressources. Comme Alexander Capron l'a soutenu en 2007, la bioéthique a un problème 10/90, car la recherche en médecine investit 90 % de ses ressources pour résoudre des problèmes affectant 10 % de la population mondiale. Aujourd'hui, le site de l'UNESCO maintient que la bioéthique est axée sur « la recherche sur les cellules-souches, le dépistage génétique, le clonage, les progrès dans les sciences de la vie ». Une étude des articles largement cités en bioéthique montre que ces écrits sont axés sur les préoccupations des pays développés. Dans les pays en développement, les cellules souches et le clonage ne sont des priorités, ni en soins de santé, ni en sciences de la santé. Les priorités des pays en développement (c'est-à-dire celles qui accroîtraient la santé des populations ou qui s'interrogeraient sur les maladies locales) sont marginalisées. Des infrastructures médicales dispendieuses et/ou peu pratiques sont abordées ou proposées. L'orientation de la bioéthique vers le premier monde était peut-être possible durant la stagnation suivant la Deuxième Guerre mondiale, mais elle devient graduellement dysfonctionnelle et même dangereuse au 21e siècle, avec le changement climatique, les mouvements des réfugiés et la migration des vecteurs de maladies. Une nouvelle bioéthique globale est nécessaire de toute urgence.
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First world bioethics and global realities

Bioethics as practiced in Europe, the United States, and Canada has a tenuous and tentative reach into the developing countries of Africa, South America, and Asia. This paper explores the problematic translation of bioethics between the Global North and South; and between resource rich and resource poor countries. It proposes that the values of prestigious and endorsed human rights document as capable of serving as a foundation for global bioethics.

In 2007, Alexander Capron's Presidential Address to the International Association of Bioethics referred to bioethics' 10/90 problem, analogizing to the observation that medical research spends 90% of its resources on problems affecting 10% of the world's population [1]. It is fair to compare academic bioethics to the pharmaceutical industry. Bioethics, prodigious scholarship on withdrawing complex life support, organ transplantation, research ethics, etc. is properly analogized to the fact that of 1400 drugs brought to market between 1975 and 1999, only sixteen were for tropical diseases and pneumonia [2]. Capron proposed that bioethicists should be more mindful of cultural diversity and forthrightly address constricted rights of intellectual freedom as well as huge disparities of wealth and health between the developed and the developing world. Today, ten years after Capron's Address, UNESCO's website on bioethics notes that ''stem cell research, genetic testing, cloning, progress in the life sciences is giving human beings new power to improve their health and control the development processes of all living species. Concerns about the social, cultural, legal and ethical implications of such progress have led to one of the most significant debates of the past century. A new word has been coined to encompass these concerns: bioethics'' [3]. UNESCO's website references its two declarations on genetics and its Universal Declaration on Bioethics and Human Rights (vid infra), which are firmly centered on clinical care and research with advanced technologies [4]. The World Health Organization sponsored Council for International Organizations of Medical Sciences (CIOMS) is similar to UNESCO [5,6]. Any review of the most widely cited bioethics articles will find that the writing and cross citations largely refer to a privileged enclave of first world concerns [7]. Stem cells and cloning are neither health care nor health science priorities of developing countries.

Bioethics' cultural missionaries

Modern bioethics is grounded on the phenomenally influential 'Principles of Bioethics' by Thomas Beauchamp and James Childress [8]. That principlism paradigm argues for four foundational principles: respect for autonomy as first over the lesser, beneficence, non-maleficence, and justice. It is consolidated in the United States and Europe. As teachers, coauthors, and editors, bioethicists functioned as advocates and cultural missionaries carrying ''principlism'' to international organizations and to developing countries. Articles track the paradigm's march in terms of grants won, Centers established, and curriculums designed [9,10]. UNESCO's extensive database of African ethics programs finds only three that do not focus mainly on research [11]. Some writers in developing countries have characterized the dissemination of principlism as 'cultural imperialism' or 'intellectual colonization' [12,13].

It is easy to imagine and instructive to consider a different way to assess the spread of the principlism paradigm. Rather than tracking the quantitative spread of Centers for principlism, a different assessment would consider the utility of that paradigm to local bioethics priorities, needs, and controversies. By such a measure, a mismatch is easy to see. Bioethics plays no role in challenging structural barriers to potable water, working sewage systems, the funding of competent programs to treat TB, the imperative to ensure

vaccination over the development of dialysis centers, the duty to ensure that community-based hospices can dispense inexpensive opiates to people who are dying, and so on [14]. Community health, not intensive care, is the central challenge and thus the arena for bioethics in developing countries. Bioethics has played little role in addressing female genital cutting — resistance to this practice, even in UNICEF and WHO, is centered within advocacy for human rights, women's rights, and child protection. CIOMS addressed physician collaboration with torture in 1982; since then, it has been quiet on medicalized torture, executions, or religion-based penal amputations. The moral challenge to those practices largely comes from human rights groups and sporadic action by medical associations acting independently of the WHO or the World Medical Organization [15]. Bioethics has not engaged governments that illegalize or circumscribe abortion or the right to express one's own sexual orientation, leaving those arguments to be developed by civil society and human rights groups. It is silent on the lack of contraception in refugee camps that results in increased number of maternal deaths, orphans, neonatal mortality, and lethal amateur abortions. The tiny number of articles on the humanity of albinos (a genetic condition that therefore fall within UNESCO's bioethics focus on genetics) circulates outside of the national bioethics communities where albinos are being killed [16—20]. In Kenya, the protection of albinos is advanced by disability rights groups rather than bioethicists [21].

Bioethics in developing countries has largely evolved in parallel with the topics pursued in developed countries. Latin American bioethics publications tend to focus on high technology, research ethics, and the like [22—25]. There is a greater emphasis on universal health care than in bioethics in the United States, which is not surprising given the United States' anomalous system of non-universal health care and US bioethicists' tendency to leave health care reform, e.g., gender equality of insurance premiums, to public policy experts [26]. A similar statement might be made about African bioethics [9,27,28]. Cuba is an exception. After the collapse of the Soviet Union, it fused autonomy-centered bedside ethics, universal health care, and carefully stated allusions to the Latin American liberation theology justice into some striking new bioethics [29].

A few bioethics journals regularly feature work addressing problems in non-OECD health care systems. A partial list includes *Asian Bioethics Review*, *Developing World Bioethics*, *Eubios Journal of Asian and International Bioethics*, *Indian Journal of Medical Ethics*, *International Bioethics*, *Journal of Bioethical Inquiry*, *Journal of Chinese Medical Ethics*, *Journal of Global Ethics*, *Monash Bioethics Review*, *South African Journal of Bioethics and Law*, *Turkish Journal of Bioethics*, *Public Health Ethics*, *Revista Bioethics*, *Revista Brasileira de Bioética (RBB)*, *Journal on African Philosophy*, and the *South African Journal of Bioethics and Law*. However, the topics of these journals' also tend to track the topics found in ''first-world'' bioethics issues (e.g., ICU care) and skirt urgent local bioethics controversies such as access to contraception or post-coital birth control. The *Journal of Chinese Medical Ethics* is silent about executions for commercial organ harvesting in the People's Republic of China.

Clinical versus public health perspectives in North-South bioethics

Even in the wealthiest countries, costly medical treatments (e.g., intensive care, organ transplantation, dialysis, or cardiopulmonary resuscitation, cell therapy, salvage chemotherapy, etc.) have negligible effects on public health outcomes compared to universal access to primary and secondary health care, public sanitation and vaccinations. Centering the field of bioethics on the moral analysis of costly health services ensures its irrelevance to health care systems and pressing health priorities in resource poor countries [30]. For example, Macedonia, Azerbaijan, and Albania have the global median per capita Gross Domestic Product (GDP) of 10,800 USD. These countries spend 250 USD to 600 USD per person per year on health care compared to 6500 USD in Switzerland. Those countries and the 113 countries with even lower per capita GDP have most of the world's population. In such countries, access to potable water, contraception, prenatal care, affordable primary care, and competent tuberculosis programs are the highest health care priorities and ironically the neglected front of bioethics [31]. Refugees — a diaspora of sixty-five million stateless persons that is approximately as populous as France — are invisible to bioethics. A third of these people live in underserviced camps; two-thirds live on the streets of nations like Jordan, Lebanon, or Turkey, where access to health care is trivial at best and, if undertaken, should entirely address public health and primary care.

These remarks on the irrelevance of a bioethics of high technology do not mean that technology-focused bioethics is irrelevant to developing countries. But it does suggest that bioethics' attention should focus on technologies with broad sociopolitical implications such as biopiracy or clinical trials that use developing countries as research plantations. It might focus on Genetically Modified Organisms (GMO) patents and national food security as well [32,33]. For example, some grain companies have tried to claim patents on local food crops or medicines derived from indigenous plants.

The 2014 Ebola outbreak in Guinea, Sierra Leone, Liberia, and Nigeria illustrates the harmful dysfunction of bioethics' parochial first world perspective [34]. Faced with a rapidly expanding outbreak, bioethicists and international health authorities raced to ''tragic choice'' resource allocation problem, focusing on how to allocate new, untested, and extremely scarce and costly first world drugs for a supervirulent new strain. There was no evidence of a new strain. The exponential increasing multi-centric outbreak was incompatible with the Ebola R0 of about 1.5, which suggested low infectivity. That R0 suggested that the Ebola outbreak was fueled by cultural practices rather than the Western science fiction conceit of a new supermutation [35,36]. Bioethicists' contributions were at best irrelevant and worse as they echoed and fuelled panicked interest in quarantines and blockades. Bioethicists should have been early advocates for anthropological investigations that would have identified the practice of collective washing of highly infected bodies as the reason for the rapid spread. When that approach was taken, the outbreak stopped. The irrelevance of bioethics

can be seen in International Organization's lessons-learned documents that do not mention bioethics [34]. One may not excuse bioethics for not having the requisite expertise. The fact that bioethicists chose to comment meant that they had a duty to learn. Bioethicists' rapid learning on topics like gene editing suggests that they are capable of self-education.

Grounding global bioethics

Principlism, the analytic paradigm for the wealthiest OECD countries, arose from philosophy and theology scholars in universities in OECD nations. It references western traditions and intellectuals. For example, Immanuel Kant is often invoked in relation to respect for the principle of respect of autonomy. Kant and the rationalists, empiricists, and utilitarians are largely alien to many countries that and cultures. It is ironic indeed that the very countries that export this paradigm do not rely on it in their civic cultures. Moral evolution in the developed world arises from progressive understandings of human and civil rights. For example, there is the English Bill of Rights of 1689 and its various successor documents, the French *Déclaration des droits de l'homme et du citoyen* of 1789, and the American Constitution and its Bill of Rights and various civil rights movements. These are profound ethics events that are flexible in being aspirational and that offer a balanced protection of individual and communitarian claims. Courts, human rights groups articulate and press the evolving boundaries of ethics in the United States and Europe.

Why did western bioethics choose academic philosophical tools that were so alien to the dominant forms of human rights discourse in their own countries and so poorly suited for export to poorer nations? Bioethics arose in countries where human rights were relatively realized and health care technology was far advanced. The arcane questions that it chose to address fell outside of the conceptual framework of human rights instruments. What is death when the heart is kept beating by a machine? Is an in-vitro fetus a person? In developing countries, the health care systems' moral challenges (that should be bioethics' priorities) pertain to indisputable persons and thus fall within the ambit of human rights instruments. Bioethicists' initial and ongoing neglect of the reality of human needs outside of academic first-world health centers bespeaks of an intense marginalization, even stigmatization, to the broader world.

Academic bioethics has not transplanted well to the culture of developing countries. University cultures are very small [37]. Civil society and the NGOs in such countries appeal to human rights and human rights instruments, rather than principlism, to advocate for progressive social ethics. Many academicians from wealthy nations are unfamiliar with the content or force of these human rights documents and thus are alienated from local forces of change. We can see: women's rights and the protection of children addressing Female Genital Cutting; human rights groups and medical societies fighting physician collaboration with torture or religiously justified penal amputations; women's groups engaging the right to have contraception and abortion; and disability rights groups working on behalf of albinos who are subject to extrajudicial murder.

The foregoing suggests that the central ''bioethics texts'' for developing countries are such works as the Convention on the Rights of Persons with Disabilities (CRPD), the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, or the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and so on. Corruption, which has a strong adverse effect on public health outcomes through its effect on potable water, vaccination rates, maternal mortality, etc., falls entirely outside of bioethics and is addressed by advocates for the rights of civil society [38]. In sum, the ethics movement on behalf of health in developing countries sits outside of the dominant human rights paradigm of ethics that is shaping developing countries' health system.

Bioethics for the whole world

In 1970, Van Rensselaer Potter recoined ''Bioethics'' as ''humanistic knowledge to forge a science for sustainable medical and environmental survival'' [39]. As the field of bioethics grew, it has become sequestered in a small pot. It is time for bioethics to be transplanted to a bigger garden. A bioethics for the global community would have these elements.

First, it must redress its neglect of public health. This would mean learning to apply epidemiologic data (rather than clinical facts) to a broader set of moral casuistries in developing countries. As climate change and ensuing disease vector and human migrations change public health in developing and developed countries, bioethics must learn about the anthropocene hypothesis and consider its implications for neglected diseases (e.g., malaria, dengue) and climate-induced population displacements [40]. The fact that such topics do not appear in bioethics journals is another of measure of its self-imposed isolation within the enclave of first world universities and academic health centers.

Second, it must more directly engage the dialectical tension arising between cultural diversity, communitarianism, and universal human rights. It is often said that western bioethics is excessively individualistic and that Africa, for example, is more communitarian [8,10,41]. West European principlism is criticized as being insensitive to the diversity of cultures and value systems. Bioethicists in developed and developing countries alike must be willing to look beyond a dichotomy between 'diversity' as merely a relative contest of contending ethnophilosophies to ground bioethics in higher order values that inevitably will be contested on the grounds that they violate local religions or laws [42,43].

The best path to a global bioethics is to ground it on human rights. Human rights documents do not simply address issues of fairness and respect for persons. They also address the degraded or stigmatized state of minorities or women that results in health disparities [44]. Human rights addresses the suppression of free speech about ethics topics that conflict with state policy or national religions that chill ethics discourse in China, Uzbekistan, and more recently in Turkey.

International human rights documents are the closest that global society has to an international moral consen-

sus. It challenges particular traditions — the chattel status of women for example, entrenched local practices (penal amputations) with the authority of international ratified treaties and conventions. They also address, in a way that bioethics has not, the sociopolitical determinants of health [45]. Their authority gives standing to the claims of bioethics as they put its practitioners in peril from local political criticism [30]. This is not a call to 'politicize' bioethics. Rather it is a call to recognize the sociopolitical milieu within which bioethics is necessarily embedded. It should be noted that international organizations' declarations have less authority than Conventions, Treaties, and International laws that are ratified and signed by nations [46]. UNESCO's laudable Universal Declaration on Bioethics and Human Rights is not ratified by signatories [47,48]. Oona Hathaway has shown that nations that are challenged by civil society with regard to international commitments that they have endorsed but do not honor move in the direction of compliance with those international conventions [49].

Third, there must be a more affordable platform for a global bioethics discussion for both print and interpersonal encounters.

Finally, bioethicists must become culturally competent, seeking venues, experiences, and colleagues outside of the enclaves that have nearly captured the field. Bioethics associations' conferences must create explicit platforms for resource poor countries and for marginalized domestic communities such as prisoners or refugees. Exaggerated fears of crime or terrorism must not confine bioethics to the illusory invincibility of Paris or New York as happened last year when a large bioethics conference was cancelled in Istanbul. As C.S. Lewis put it, ''Courage is not simply one of the virtues, but the form of every virtue at the testing point.'' A bioethics without courage, cannot promote virtue.

Author contributions

SHM conceived of this review and drafted the initial manuscript. AKL contributed to the literature search and the drafting of the manuscript. Both authors have read and approved the final version of the manuscript for publication.

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Disclosure of interest

The authors declare that the work was done in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest. This paper is their only work and has not been influenced or edited by any other person or institution. The authors accept full responsibility for this manuscript.

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